

Electronic journals

Many of the points made by Dr Kumar (December 1996 *JRSM*, p 662) are echoed by our own experience in the first few months of trying to start a new electronic journal. Already, however, we have learned a few lessons worth recording.

Electronic journals do not threaten paper journals: they have very different abilities and weaknesses, and so are suited to different tasks. Electronic journals face difficulties of common browser formats that require widespread agreement before they are universal. The problem of archiving is a real one and no simple solution is yet found. The cost of reading equipment (e.g. personal computers) is still prohibitive although net-specific terminals may ease this, and given the ability to time-share PCs the cost may not be so great. The quality of images that can be readily downloaded is also poor but again will improve as access speeds soar with the advent of ISDN speeds through cable or satellite providers.

On the other hand, electronic journals have tremendous advantages too. They are instantly accessible, publication times are fast, and hypertext language makes browsing and linking valuable. Anyone can access and read our journal. Discussion can take place and yet be policed and edited by use of a subscription list. This requires each 'subscriber' to the journal (which is free to all) to register on a mailing list. Thenceforth all comments on papers are passed through the editorial board and 'bounced' out automatically after checking to each subscriber for further comment, which in turn is published in the same way. This avoids the poor behaviour seen in some use-groups.

Since publication and discussion are rapid, the journal is an ideal format in which to call for help: a rare or difficult case can attract widespread responses. This is a facility that is not provided in any other way than by bulletin boards. Of course, lay persons can also call for help or advice, and often do. This is another useful service not available in traditional journals, sequestered as they are from the public in inaccessible libraries, and unlikely in any case to publish such requests. It remains to be seen whether any of these properties will prove enduring in the world of electronic publishing, but any readers who would like to watch a journal evolve should point their browsers at our web page:

<http://www.leeds.ac.uk/handsurgery/ejhome.htm>

All suggestions are welcome (and rapidly responded to).

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Medical scientism

Mr Leggett's thoughtful article (February 1997 *JRSM*, pp 99–101) reminded me of Donald Winnicott's dictum that disease creates stereotypes while health is infinitely various; the task of the physician being to allow the latter to escape the former. Perhaps it is time that our scientific deans find room in the medical curriculum, overloaded as it is with factual information, for a little philosophy and some social anthropology.

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Complementary medicine in the medical curriculum

Americans, just like their British counterparts, are disenchanted with the current health care system and have turned in increasing numbers to alternative medicine for answers. A 1993 paper¹ indicated that about one-third of the adult population uses some form of unconventional therapy at an estimated cost of \$13 billion dollars a year. Curriculum changes of the sort proposed by Dr Rampes and colleagues (January 1997 *JRSM* pp 19–22) are being tried.

In 1992 Congress created the Office of Alternative Medicine (OAM) to investigate the efficacy of these alternative treatments. An important research area of the OAM has been psychoneuroimmunology or the mind–body connection, which is critical to holistic healing. Specific natural treatments under investigation include homoeopathy, Ayurveda, yoga, t'ai chi, acupuncture, American Indian medicine, and manipulative and touch therapy. In July 1996, a large conference on religion and medicine was held to discuss the 'faith factor' and its impact on medical care. Participants included researchers from Harvard, Georgetown, The National Institutes of Health and the National Institute for Healthcare Research. Clearly, academics are finally putting alternative medicine under the microscope to determine whether these

treatments are inactive, harmful or beneficial.

Empirical studies have also focused on vitamins/minerals, antioxidants, herbals and macrobiotics, since many of these remedies can be harmful at certain doses or interfere with other medications. Concerns about the purity of these products have also been raised, and the Herb Research Foundation and the American Botanical Council have been collaborating with European experts to identify safety problems within the unregulated botanical industry.

The most attractive aspect of alternative medicine is its emphasis on the person instead of the disease and the important role the patient plays in the healing process. This model includes listening and communicating with patients about prevention and self-care. In the US there has been tremendous resistance to bridging the gap between alternative and traditional Western medicine; but some large hospital centres, such as the Mind/Body Institute at Harvard Medical School, have successfully integrated the practice of mainstream and alternative medicine. An increasing number of medical schools and residencies in primary care have also begun to include alternative medicine texts within the curriculum. Specialized training institutions in alternative health are also increasing, both in the US and abroad, and these can no longer be ignored by the conventional medical community. No one therapeutic system will be a success for every patient, therefore physicians must learn to consider alternative regimens as adjuncts to comprehensive care. This approach reflects the practical meaning of 'holistic medicine'.

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REFERENCE

- 1 Eisenberg, DM, Kessler, RC, Foster, Norlock, FE, Calkins, DR, Delnanco, TL. Unconventional medicine in the United States. Prevalence, cost and patterns of use. *N Engl J Med* 1993;328:246–52

Randomized trial of homoeopathic arnica

Samuel Hahnemann was well-meaning but unaware of the distinction between symptomatology and pathology. The medical system

he proposed as an alternative to exsanguination and other damaging practices was a distinct advance¹. But a few things have happened in science since 1810, especially in chemistry, pharmacology, genetics, molecular biology and immunology. These disciplines were not advanced by people who were unable to distinguish between open-mindedness and plain absurdity.

That Mr Hart and his colleagues (February 1997 *JRSM*, pp 73–8) should have found that 'homoeopathic arnica' has no effect on pain and postoperative recovery after hysterectomy is neither here nor there. What is important is that a respected medical journal should seem to imply that, however ridiculous, the inclusion of a subject in its pages is justified so long as its statistical treatment is impressive. It is also important that it should seem to imply the possibility that phrases like 'C30 potency' have any scientific meaning whatsoever. If a word like 'potentiation' is used to mean 'increase in power' well and good. But if it is used to mean 'increase in power by a process of dilution to the extent that not a single molecule of the substance being diluted can logically remain' then surely the limits of absurdity have been breached.

Pre-scientific pharmacology at the level of, say, Culpeper², was characterized by assertions such as 'arnica is good in . . .'. That, at least, whether true or false, was a reasonable proposition. But to take some arnica and, by serial dilution, laboriously to remove every scrap of it and then to suggest

that the diluent now possesses, in greatly enhanced degree, the original therapeutic powers of the arnica (however delusory), is to revert to plain superstition.

What are intelligent lay people to make of this? What kind of effect can it have on the minds of medical students to whom we owe a duty of rigorous care in the presentation of demonstrable truth? Not, I submit, a very salutary one.

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REFERENCES

- 1 Hahnemann, S. *Organon of the Rational Art of Healing*. Köthen, 1810
- 2 Culpeper, N. *The English Physician, or Herball*. London, 1653

The anatomy lesson of Professor Barge

Hendriksen and Hijmans (November 1996 *JRSM*, pp 649–50) described how, in the early days of the German occupation in Leiden, Professor JAJ Barge gave his anatomy class a series of lectures that deliberately undermined the racial theories of the Nazis. The last of these lectures, explicitly denying the existence of a German race, inspired the medical students to join a strike in the University. The article proposed a fund to commemorate Barge's

courage and integrity by means of an annual lecture—which the authors wryly suggested could be about the backbone of man. Several readers inquired about the possibility of contributing to such a fund.

The proposal has become a reality. The Barge Foundation has now been established to provide for scientific and educational activities in physical anthropology; and part of the programme is an annual lecture on ethical aspects of medicine and on the role of the physician in society. The goal is £300 000, and £250 000 has already been given. Further donations are most welcome. Administrative expenses are very low; there are no paid staff. Would prospective donors from outside the Netherlands please contact me first, so that we can avoid the high cost of cashing foreign cheques.

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CORRECTION Development and evaluation of a novel patient information system

In Table 2 of this paper (October 1996 *JRSM*, pp 557–600) the phrases 'Quite easy to read' and 'Very easy to read' have been transposed: the numbers and percentages should, however, remain as in the present order.